July 1, 2006 – June 30, 2007

Benefit	CareFirst Blue Choice
Deductible	N/A
Out-of-Pocket Maximum	N/A
PHYSICIAN SERVICES	
Surgeon	Covered in full inpatient, $10 Copay PCP; $20 Specialist in office (facility covered in full)
In-Hospital	Covered in full
HOSPITAL	
Hospital Room/Semi Private*	Covered in full
Outpatient Surgery**	$10 Copay PCP/$20 Specialist
Emergency Care (within 72 hours) • Facility • Facility/Practitioner • Provider's Office	$50 Copay Emergency Room (waived if admitted) $20 Copay Urgent Care Center $10 Copay PCP /$20 Specialist
MEDICAL SERVICES	
Diagnostic X-rays	Covered in full
Radiation & Chemotherapy	Covered in full inpatient $20 Copay outpatient
Laboratory Tests	Covered in full
Allergy Testing	$10 Copay PCP/$20 Specialist
Allergy Treatment/Injections	$10 Copay PCP/$20 Specialist
Physical Therapy	$20 Copay up to 30 visits per condition per contract year when approved by HMO/HMO physician (PT & OT combined)
PREVENTIVE CARE	
Well Baby & Child Care	$10 Copay PCP
Immunization	$10 Copay PCP
Annual Physical Exam	$10 Copay PCP/$20 Specialist
Annual Gynecological Exam	$10 Copay PCP/$20 Specialist
Eye Exams	$10 Copay at Davis Vision Provider one per calendar year
Eye Glasses	Discounts available through Davis Vision
OFFICE	
Medical Visits for Illnesses	$10 Copay PCP/$20 Specialist
SPECIAL SERVICES	
Hearing aid evaluation test (one every 36 months)	$20 Copay/visit (once every year)
Hearing aids (one every 36 months)	Limited to maximum of $1,400 every 36 months for one hearing aid for each hearing impaired ear; under 18 only
Home Health Care Visits	Covered in full
Maternity Care	Hospitalization covered in full. Professional pre/post natal care $20 Copay per visit, not to exceed $200 per pregnancy
Infertility Services Artificial Insemination & In Vitro Fertilization	Counseling and testing, $20 Copay with specialists, artificial insemination covered at 50% of plan allowance; IVF covered at 50% of plan allowance – limited to 3 attempts per live birth; lifetime maximum $100,000
Ambulance (when medically necessary)	Covered in full
MENTAL HEALTH/SUBSTANCE ABUSE COMBINED	
Inpatient Care*	Inpatient: (includes Halfway House) Covered in full. Partial Hospitalization: 60 days per year, $5 Copay per day

Outpatient Care (services must be preauthorized)	Visits 1-5, 20% coinsurance Visits 6-30, 35% coinsurance Visits 31+, 50% coinsurance

PRESCRIPTION DRUG PROGRAM	
	$5 Copay – generic drugs $10 Copay – brand-name preferred drugs $25 Copay – non-preferred drugs/ $4,000 maximum per person Maintenance drugs: Retail – 3 Copays Mail Order – 2 Copays

This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Health Benefits Certificate, the Group Benefit Guide or the Group Service Agreement.

AB-Allowed Benefit.

**Inpatient stays require precertification. ***If the hospital bills for use of the facility or provider bills for use of his office, the member will be subject to the appropriate copays.*